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GENTIVA HEALTH SERVICES I I I	5425 LOUIE LANE, SUITE B RENO, NV 89511

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G 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of the Medicare re-certification survey under 42 CFR Part 484 - Home Health Services, conducted at your agency from August 3, 2009 through August 7, 2009. The active census on the first day of the survey was 210. Twenty-five clinical records were reviewed, including four closed records. Fifteen home visits were conducted. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified.	G 000		
G 116	484.10(f) HOME HEALTH HOTLINE The patient has the right to be advised of the availability of the toll-free HHA hotline in the State. When the agency accepts the patient for treatment or care, the HHA must advise the patient in writing of the telephone number of the home health hotline established by the State, the hours of its operation, and that the purpose of the hotline is to receive complaints or questions about local HHAs. The patient also has the right to use this hotline to lodge complaints concerning the implementation of the advanced directives requirements.	G 116		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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G 116	Continued From page 1 This STANDARD is not met as evidenced by: Based on review of patient admission materials, staff interview and patient interview, the agency failed to advise patients verbally and in writing of the toll free home health hotline telephone number established by the state, for 2 of 25 patients (Patients #8, 13). Findings include: Review of the patient admission material that the agency gave to every patient on admission revealed the agency did not provide the toll-free hot line number in the information provided. The agency had the business phone numbers and mailing address of the State Bureau of Licensure and Certification. An interview with the Branch Director was conducted on 8/3/09. During this interview the Branch Director confirmed she was not aware of the toll-free hot line number. She acknowledged that patients were not being informed of the hot line number, because the agency did not have it as part of their admission information. Patient #8 Patient #8 had a Start of Care (SOC) with the agency on 7/26/09 following surgery for a hip replacement. During a home visit on 8/5/09, the patient disclosed that she was not aware of a Health Home Agency (HHA) hotline, the purpose of the hotline or where to find the telephone number for the hotline.	G 116		

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G 116	Continued From page 2 Patient #13 Patient #13 was admitted on 7/22/09 with diagnoses including pressure ulcer, non-insulin dependent diabetes mellitus, a right sided below the knee amputation and a left sided above the knee amputation. On 8/4/09 in the morning during a home visit, Patient #13 indicated he was not informed of a toll free home health hotline number. The folder the nurse left with the patient after admission lacked documentation regarding a home health hotline phone number for the patient to call, reasons why the patient might call and specific hours when calls would be accepted.	G 116		
G 121	484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA. This STANDARD is not met as evidenced by: Based on observation, interview and document review, the agency failed to ensure accepted professional standards and principles were followed regarding bag technique/infection control for 1 of 25 patients (Patient #24). Findings include: Patient #24 Patient #24 was admitted on 6/30/09 with diagnoses including an infected abrasion on the forearm, chronic obstructive pulmonary disease	G 121		

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G 121	Continued From page 3 and senile dementia. On 8/5/09 at 9:00 AM during a visit to the assisted living facility where Patient #24 resided, the registered nurse (RN) failed to perform hand hygiene before retrieving an item from her nursing bag on two different occasions. The RN failed to perform hand hygiene between glove changes on one occasion. On 8/5/09 in the afternoon, the Director of Nursing confirmed the agency's policy was for hand hygiene to be performed prior to retrieving items from the nursing bag and in between glove changes. According to the agency's policy on bag technique, "... 12. Wash hands before reentering bag for additional equipment..." According to Home Care Nursing Practice: Concepts and Applications by Robyn Rice, PhD, RN, " ...Wash hands with liquid soap and water immediately after removing gloves. If soap and water are not available, antiseptic hand cleanser or towelettes may be used. Hands should then be washed with soap and water as soon as possible ... "	G 121		
G 144	484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur. This STANDARD is not met as evidenced by:	G 144		

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G 144	Continued From page 4 Based on policy review, staff interview and chart review, the agency failed to ensure the registered nurse (RN) case managers regularly re-evaluated and supervised the licensed practical nurses (LPNs) and certified nursing assistants (CNAs) providing patient nursing and personal care needs for 8 of 25 patients (Patients # 3, 4, 20, 7, 10, 12, 16, 18). Findings include: Review of the Patient Care Supervision policy indicated the company policy regarding patient care supervision of LPNs and CNAs would be conducted at a frequency of every 60 days. A qualifier within this policy specified that Medicare certified agencies were to have the RN perform an on-site supervisory visit to each patient receiving home health aide services at least every 14 days. There was no qualifier to specify any different frequency of supervisory LPN visit frequencies. Review of the clinical note revealed that there was a pre-printed area to indicate if a supervisory visit was conducted. An interview with the Director of Nursing/Clinical Management (DON/CM) was conducted on 8/5/09. The DON/CM acknowledged that this would be where the RN was to document whether a supervisory visit was conducted. She revealed the LPNs were supervised only every 60 days if they were assigned to a specific patient. The two LPNs were usually assigned to fill in, only seeing a patient if the registered nurse was not available. The DON/CM acknowledged that the LPNs were not being supervised by the RNs when they saw patients who were assigned to RNs. The	G 144		

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G 144	Continued From page 5 DON/CM acknowledged the agency could not demonstrate the LPNs were being supervised regarding their care for patients An interview with an LPN (Employee #2) at 8:00 AM on 8/7/09, confirmed that she did not carry a permanent case load, but filled in as relief for the registered nurses. Patient #3 Patient #3 was admitted to the agency on 5/14/09 with the primary diagnosis of a pressure ulcer of the right hip. Review of the visit record revealed Patient #3 was seen by an LPN on 7/3/09, 7/8/09, 7/9/09, and 7/10/09. The subsequent RN visit done on 7/4/09 and 7/11/09, had no evidence of an LPN supervisory evaluation of care provided. Patient #4 Patient #4 was admitted to the agency on 6/18/09 and was seen weekly. Review of the visit record revealed Patient #4 was seen by the LPN on 6/29/09 and 7/14/09. There was no evidence that either on 7/7/09 or 7/21/09, when the RN made a visit, that an LPN supervisory visit was performed. Patient #20 Patient #20 was admitted to the agency on 8/24/08 and discharged on 1/23/09. Review of the last two 60 day recertification periods revealed Patient #20 was seen by the LPN on 12/30/09. A subsequent visit on 1/3/09, was conducted by the RN. There was no evidence a supervisory LPN visit was conducted.	G 144		

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G 144	Continued From page 6 Patient #7 Patient #7 had a Start of Care (SOC) with the agency of 11/19/08. Her diagnoses included multiple sclerosis, contractures and depression. She was wheelchair bound and paralyzed with the exception of her left hand. She was receiving Home Health Aide (HHA) visits 2 times a week for 9 weeks during the Recertification period of 5/18-7/16/09. The HHA visits were for assistance with personal care. Review of Patient #7's medical record disclosed that the file lacked documented evidence of supervising visits of the HHA being conducted by the registered nurse within the specified time frames. There were no supervising visits documented from 6/1 to 6/15/09. In an interview with the Director of Nurses (DON) on 8/4/09, the DON concurred that there were no supervisory visits for a time period of fifteen days. Patient #10 Patient #10 had a SOC with the agency of 6/3/09 with diagnoses of dementia, Paget's Disease and a pressure ulcer of the buttocks. She resided with an adult age son. The patient was receiving HHA visits of 2 times a week for 3 weeks during the Certification period of 6/13-8/01/09. The HHA visits were for personal care of the patient. Patient #10 received HHA visits from 6/16-7/3/09. The file lacked documented evidence that any supervisory visits were conducted by registered nurse staff. In an interview with the DON on 8/6/09, it was agreed that no supervising visits had been made.	G 144		

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Patient #12

Patient #12 was admitted on 1/24/09 with diagnoses including late effects from a stroke, dysphagia and malaise and fatigue. The patient was re-hospitalized from 1/30 through 2/3/09.

A resumption of care (ROC) Case Conference note dated 2/9/09 had entries regarding skilled nursing frequencies. There was no documentation regarding physical therapy, occupational therapy and social services, all of whom were seeing Patient #12 prior to hospitalization. The document lacked information regarding the patient's recent hospitalization (diagnoses, course of treatment, progress made, etc.). There were no signatures on the document.

Patient #16

Patient #16 was admitted on 7/2/09 with diagnoses including congestive heart failure (CHF), generalized muscle weakness and hypoxemia. The patient was re-hospitalized from 7/21/09 through 7/23/09 for exacerbation of CHF and hypoxia.

A resumption of care (ROC) Case Conference note dated 7/23/09 indicated skilled nursing, physical therapy (PT) and occupational therapy (OT) was to be provided. Only a nurse signed the form. There was no indication the PT and OT were at the case conference discussing Patient #16's needs.

Patient #18

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G 144	Continued From page 8 Patient #18 was admitted on 6/12/09 with diagnoses including pressure ulcer of the lower limb, venous insufficiency and chronic obstructive pulmonary disease. The patient was treated in the emergency room on 6/3/09 for lacerations sustained in a fall at home. According to the occupational therapy assessment dated 6/24/09, the patient sustained a fractured pelvis (date not noted). A Case Communication note dated 6/18/09 indicated skilled nursing (SN), physical therapy (PT) and certified nursing assistant (CNA) were contacted regarding Patient #18's resumption of care. All three disciplines were circled. There was no name next to the designation to indicate who was actually contacted and conferenced with regarding the patient's care. None of the three disciplines had signed off that they had received information regarding the patient's condition status post hospitalization.	G 144		
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Based on interviews and record review, the agency failed to ensure care followed the written plans of care established by the physician for 9 of 25 patients (Patients #12, 18, 7, 10, 22, 1, 2, 3, 4). Findings include:	G 158		

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G 158	Continued From page 9 Patient #12 Patient #12 was admitted on 1/24/09 with diagnoses including late effects from a stroke, dysphagia, malaise and fatigue. Patient #12 was re-admitted to a hospital on 1/29/09 for treatment of a urinary tract infection and discharged on 2/1/09. A resumption of care (ROC) was completed by a registered nurse on 2/9/09, per family request. The ROC included orders for skilled nursing (SN) to see Patient #12 two times a week for three weeks and then one time a week for four weeks. Nursing notes in Patient #12's clinical record revealed SN saw the patient one time a week for one week; two times a week for two weeks; and then one time a week for two weeks. Patient #12's clinical record lacked documentation indicating the physician was notified of the changes in the SN schedule. The clinical record lacked a physician's order for the changes in the SN schedule. Patient #18 Patient #18 was admitted on 6/12/09 with diagnoses including pressure ulcer of the buttock, venous ulcer of the lower extremities, venous insufficiency and chronic obstructive pulmonary disease. The patient was treated in the emergency room on 6/3/09 for lacerations sustained in a fall at home. On 6/15/09, Patient #18 experienced a hypotensive episode and was readmitted to the	G 158		

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hospital where she was also diagnosed with a urinary tract infection. According to the occupational therapy assessment dated 6/24/09, the patient " had fall at home X (times) 2 w/ fx (fractured) pelvis " (dates of falls not noted).

A resumption of care (ROC) visit was completed for Patient #18 on 6/21/09. The ROC paperwork included a physician's order dated 6/21/09 which read, "... on bilateral lower extremities: cleanse c (with) wound cleanser and gauze. Apply Silvadene to open areas using tongue depressor or sterile cotton applicator. Cover c Xeroform gauze. Wrap c Kerlix. Secure c regular tape. To be done daily by caregiver. SN (skilled nurse) to instruct c/g (caregiver)."

The clinical record contained a physician's order dated 6/22/09 for SN to see Patient #18 "... seven times a week for one week and then three times a week for six weeks for disease process teaching wound care and to LEs (lower extremities) and buttocks ..."

Nursing notes in the clinical record revealed SN saw Patient #18 on 6/20, 6/21, 6/22, 6/24 and 6/25/09 to perform wound care and teach the caregiver how to do the same. The clinical record lacked a physician's order to decrease SN visits from seven to five the week of 6/20/09.

According to documentation in the clinical record, SN performed the wound care every visit from 6/12/09 through 7/27/09. There was no documentation indicating the caregiver gave a return demonstration of completing the wound care. There was no documentation indicating the caregiver refused to learn or was unable to tolerate providing the wound care.

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Patient #7

Patient #7 had a Start of Care (SOC) with the agency of 11/19/08. Her diagnoses included multiple sclerosis, contractures and depression. She was wheelchair bound and paralyzed with the exception of her left hand. She was receiving skilled nursing visits 2 time a week for 1 week, then 3 times a week for 1 week and 2 times a week for 7 weeks. She also received Home Health Aide (HHA) visits 2 times a week for 9 weeks during the Recertification period of 5/18-7/16/09.

In the record was a physician's order written 5/23/09. The order was to cleanse the wound of Patient #7 with wound cleanser and gauze, then apply protective ointment to the wound edges, applying arglass powder or film to the wound bed and cover with gauze and medfix.

On 6/29/09, the nurse documented in her skilled visit notes "will treat wound today but if fully closed next visit will quit dsg changes and use protective ointment."

For the 7/2/09 home visit, the nurse charted "pressure ulcers now healed. Teaching husband to apply protective ointment to healed areas of coccyx daily."

On 7/3/09, in a physician's communication, the nurse documented " pt's pressure ulcers on coccyx and buttocks, stage 2, now resolved." The nurse requested additional visits for observation and assessment of the wounds. It was not mentioned that the nurse had stopped

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the wound care orders or that the husband of Patient #7 had been instructed to use protective ointment to the healed areas daily. The wound care was discontinued without a physician's order and a new treatment was instituted without the physician's order.

The week of 7/11/09, Patient #7 was to have two home health aide visits. There was no documentation that a second visit had been made.

The agency Director of Nurses agreed that there was no documentation of the second visit.

Patient #10

Patient #10 began services with the agency on 6/3/09 with diagnoses of a pressure ulcer of the buttock, dementia and Paget's Disease.

Orders included an evaluation to be done by the social worker for alterative living and community resources. The file contained no evidence that the evaluation had been completed.

In an interview with the Director of Nurses on 8/5/09 at 11:00 AM, she agreed that there was no documentation by the social worker that Patient #10 had been seen as ordered. The social worker was on vacation out of the country and could not be interviewed. The DON could not confirm if the evaluation had been completed.

Patient #22

Patient #22 had a Start of Care (SOC) with the agency of 4/19/09. His diagnoses included non traumatic brain dysfunction, panhypopituitarism

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G 158	Continued From page 13 and some behavorial problems. During the initial Certification period of 4/19-6/17/09, Patient #22 was to receive skilled nursing visits 3 times a week for 1 week. Documentation revealed that only one visit was made for the week. During the Recertification period for 6/18-8/16/09, Patient #22 was to receive one skilled nursing visit per week for four weeks. For the week of 6/20/09, there was no documentation of any skilled nursing visit. The Director of Nurses agreed that there was no evidence that the visits had been completed as ordered. Patient #1 Patient #1 was admitted to the agency on 11/28/08, and discharged on 1/31/09. Review of the clinical record revealed his frequency order was revised on 12/09/08 following an acute care hospitalization. Patient #1 was to be seen three times a week for four weeks. He was seen twice the week of 12/9/08 and 12/27/08. There was no evidence of the physician being informed. Patient #2 Patient #2 was admitted to the agency on 7/24/09, following an acute and skilled care facility admission. He resided in an assisted living facility. Review of his medication profile revealed that the registered nurse documented Patient #2 was to receive Spiriva inhalent, one capsule by mouth daily. He also received Advair diskus	G 158		

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G 158	Continued From page 14 250/50, one puff twice a day. Both of these were new drugs. A home health visit was conducted on 8/4/09 with the primary nurse, the same registered nurse (Employee #7) who admitted Patient #2. The RN explained that a pre-measured capsule of the medication (Spiriva) was to be put in the inhalent mouthpiece. This action punctured the capsule allowing the medication inside to be released. The mouthpiece was then placed in the mouth and the medication was inhaled. Employee #7 confirmed that the Advair diskus was administered the same way, the inhalant mouthpiece placed in the mouth and the medication was inhaled. The RN acknowledged that documenting the Spiriva to be taken "one capsule by mouth" could be interpreted as the Spiriva medication was to be swallowed, not inhaled. The RN acknowledged the medication should have been indicated to be inhaled. The home health visit also revealed Patient #2 required oxygen continually, but this was not on his medication profile. Review of Patient #2's medications on the plan of care/medication profiles, compared to his medications at the assisted living revealed a jar of Miconazole Nitrate 2% topical fungal powder to be applied to the reddened areas. This jar was labeled with Patient #2's name and was located on the top of a bathroom cabinet. The assisted living staff or Employee #7 denied any knowledge of this medication or its purpose. Patient #3 Patient #3 was admitted to the agency on 5/14/09	G 158		

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with the primary diagnosis of a pressure ulcer of the right hip. Patient #3 resided in an assisted living facility. The wound care ordered was to clean the wound with wound cleaner and gauze. Apply skin prep to the skin around the wound and protective ointment to the wound edge, pack with one-half inch Nugauze, cover with optifoam, pad and secure with medfix (tape).

A home visit was conducted with the licensed practical nurse (LPN) (Employee #2) on 8/5/09, to observe wound care to the pressure ulcer. It was observed Employee #2 did not use the protective ointment as ordered. After the wound care was completed, the LPN confirmed she did not use the protective ointment because the skin looked like it was in good condition. She acknowledged that she was aware the ointment was part of the wound care orders.

After the patient visit was completed the LPN spoke with Patient #3's primary caregiver for the shift. She asked if there were any new medications and asked if the Tylenol was still being given as needed. The primary caregiver confirmed there were no new medications, but the Tylenol was being given routinely, every four hours. The LPN did not ask to see the new order. The LPN replied that she did not check the med profiles. That was the nurse's (RN) responsibility.

Patient #4

Patient #4 was admitted to the agency on 6/18/09, following an acute care hospitalization for deep vein thrombosis. Patient #4 was 103 years old and this was the first time she ever had a blood clot. She resided at a small group home. She had no mental deficit, but required

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assistance with her daily activities. The initial referral specified to admit Patient #4 in the morning and obtain a protime on admission. Patient #4's subsequent orders were for nursing to see the patient twice a week for four weeks.

Review of the record revealed Patient #4 was admitted at 1:00 PM on 6/18/09. There was no evidence the physician had been informed of the delayed admission. Further review of the record revealed Patient #4 was only seen once a week for the four weeks by the nurse.

Patient #4's clinical record also revealed the following: a physician's order to obtain a protime on 6/22/09. This lab was obtained on 6/23/09. An order to obtain lab work on 7/13/09, revealed the lab was done on 7/14/09.

The chart review also revealed there had been no further nursing visits since 7/21/09. There was no evidence the physician had been informed nursing was not seeing Patient #4 as ordered or the labs were not done on the days they were ordered. There was also no evidence the physician had been informed nursing was no longer seeing the patient, an inquiry whether he wanted nursing to continue or evidence to inform the physician, therapy, caregiver, and/or the patient had been informed that nursing was no longer coming.

A home visit for Patient #4 was conducted on 8/5/09. Review of the medications that Patient #4 was currently taking revealed her Coumadin dose was changed from 2.5 milligrams (mg) alternating with 5 mg every other day to 3 mg alternating with 5 mg every other day. A conversation was overheard with the physical

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G 158	Continued From page 17 therapist and the caregiver. The caregiver was asked if there were any new medications, but not if any medications had been changed. The caregiver replied there were no new medications. An interview with the Director of Nursing/Clinical manager (DON/CM) on 8/5/09, revealed there was no explanation why nursing visits were not done on the day or times the physician requested for Patient #4. The DON/CM could not explain why nursing did not see Patient #4 as ordered.	G 158		
G 159	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. This STANDARD is not met as evidenced by: Based on record review and observation, the agency failed to carry out the order for the assessment and instruction in the use of oxygen equipment and safety precautions for 1 of 25 patients (Patient #9). Findings include: Patient #9 began service with the agency on 7/09/09. Diagnoses included post care for leg fractures and chronic obstructive pulmonary disease. She resided with an adult son. She was 96 years old.	G 159		

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G 159	Continued From page 18 Patient #9 was to receive continuous oxygen via a nasal cannula. During a home visit, the patient revealed that she was using the oxygen primarily only at night. It was observed that lying on the floor of the living room was a "pyramid" of six small oxygen cylinders. They were not secured in any way. In the patient's bedroom was a small oxygen cylinder complete with tubing and a nasal cannula propped against a chair. This cylinder was not in a stand or secured in anyway. An oxygen concentrator was located next to the patient's bed with an extremely long length of tubing lying on the floor. All of the observed situations presented a potential safety hazard involving oxygen.	G 159		
G 165	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Drugs and treatments are administered by agency staff only as ordered by the physician. This STANDARD is not met as evidenced by: Based on record review and staff interview, the agency failed to obtain orders for specific wound care, the drawing of laboratory tests, the administration of certain medications, and failed to administer drugs and treatments only as ordered by the physician for 7 of 25 patients (Patients #6, 7, 23, 12, 13, 18, 24). Findings include: Patient #6 Patient #6 started on service on 6/26/09 with the diagnoses of open wounds of the legs and arms and dementia. The patient had a past history of	G 165		

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Methicillin Resistive Staph Aureus (MRSA). She was wheelchair bound due to a previous stroke and lived in a group home.

In reviewing the record, a set of laboratory results were noted for Patient #6. The results indicated that the blood sample had been submitted by the home health agency. No order for the laboratory test could be located nor was there documentation in the home visit progress notes of any blood draw. On 8/3/09 at 1050 AM, the Director of Nurses agreed that the missing documentation could not be located.

Patient #7

Patient #7 had a Start of Care (SOC) with the agency of 11/19/08. Her diagnoses included multiple sclerosis, contractures and depression. She was wheelchair bound and paralyzed with the exception of her left hand. She was receiving skilled nursing visits for the purpose of wound care and assessment.

On 5/23/09, a physician's order was obtained for wound care for Patient #7. The Stage II pressure ulcer on the left buttock was to be cleansed with wound cleaner and gauze, then protective ointment applied to the wound edges. Arglass powder or film was then to be applied to the wound bed and covered with gauze and medfix with each skilled nursing visit.

The documentation for the skilled nursing visit on 6/29/09 indicated "will treat wound today but if fully closed next visit will quit dsg changes and use protective ointment." On 7/2/09, the nurse documented "pressure ulcers now healed. Teaching husband to apply protective ointment to

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healed area of coccyx daily." In the record was a physicians's communication and interim order sheet from Patient #7's nurse to the physician. Dated 7/3/09, the nurse revealed that the pressure ulcers on the coccyx and buttocks were now resolved. The nurse requested additional visits for observation and assessment of the healed areas for several weeks. The nurse did not obtain an order from the physician to discontinue the wound care prior to stopping the treatment, nor did the nurse inform the physician that protective ointment was continuing to be used on the "healed pressure ulcers."

Patient #23

Patient #23 had a Start of Care (SOC) with the agency of 4/19/09. His diagnoses included non traumatic brain dysfunction, panhypopituitarism and some behavorial problems.

On 7/7/09, the nurse documented in the home visit progress note that labs had been drawn for Patient #23 and delivered to the lab. No order could be located in record for the labs to be drawn. The Director of Nurses (DON) was asked to produce the order for the laboratory tests. An order could not be located.

Patient #12

Patient #12 was admitted on 1/24/09 with diagnoses including late effects from a stroke, dysphagia and malaise and fatigue.

Patient #12 was readmitted to a hospital on 1/29/09 for elevated blood pressure and discharged on 2/1/09. A resumption of care

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(ROC) was completed by a registered nurse on 2/9/09, per family request.

An occupational therapist (OT) evaluated Patient #12 on 1/27/09 and obtained a physician's order to see the patient two times a week for two weeks.

During the second week on service, Patient #12 was hospitalized. After the patient returned home, OT saw the patient one time (on 2/9/09) and discharged the patient.

The clinical record lacked orders for OT to resume services after Patient #12 returned home from the hospital.

Patient #13

Patient #13 was admitted on 7/22/09 with diagnoses including pressure ulcer, non-insulin dependent diabetes mellitus, a right sided below the knee amputation and a left sided above the knee amputation.

On 8/4/09 in the morning during a home visit, Patient #13 revealed he took the following medications:

-- Temazepam 15 milligrams two tablets at bedtime "for at least a year"
-- Peptic Relief (generic Pepto Bismol) as needed for indigestion
-- Spironolactone 25 milligrams two tablets by mouth every night at bedtime

According to the plan of care signed by Patient #13's physician, Temazepam and Peptic Relief were not ordered. The Spironolactone was

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G 165	Continued From page 22 ordered to be taken "PRN (as needed) for blood pressure." Patient #18 Patient #18 was admitted on 6/12/09 with diagnoses including pressure ulcer of the buttock, venous ulcer of the lower extremities, venous insufficiency and chronic obstructive pulmonary disease. A skilled nursing (SN) note dated 7/6/09 revealed the registered nurse (RN) provided wound care to Patient #18 as follows: "Cleansed with wound cleanser/saline ... L (left) LE (lower extremity) duoderm, guaze, abd (abdominal) pad/buttocks-duoderm ... covered with Kerlix secured with tape" A SN note dated 7/20/09 revealed the RN applied "... Silvadene and Excell on LLE (left lower extremity) ..." A physician's order dated 6/29/09 indicated the wound care for Patient #18's lower extremities was "Cleanse with wound cleanser and gauze. Apply Xcell sheet to open areas. Wrap with Kerlix, secure with tape ..." A SN note dated 7/27/09 revealed the RN provided care to Patient #18's "left elbow 1/2 cm stage II pressure ulcer wound cleanser; telfa drsg (dressing) 4 x 4 guaze and self adhesive ace wrap" The clinical record lacked evidence of a physician's order for the wound care to the left elbow. On 9/4/09 at 12:40 PM, the director of nursing confirmed there was no physician's order for the	G 165		

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G 165	Continued From page 23 elbow wound care. Patient #24 Patient #24 was admitted on 6/30/09 with diagnoses including an infected abrasion on the forearm, chronic obstructive pulmonary disease and senile dementia. The plan of care included orders for Patient #24 to be seen by skilled nursing (SN) for wound care three times a week for one week, two times a week for three weeks, and then one time a week for three weeks. According to documentation in the clinical record, Patient #24 was seen by SN for wound care three times one week and then two times a week for four weeks.	G 165		
G 172	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse regularly re-evaluates the patients nursing needs. This STANDARD is not met as evidenced by: Based on record review and observation, the registered nurse failed to re-evaluate the needs and obtain orders for needed changes for 2 of 25 patients (Patients #16, 18). Findings include: Patient #16 Patient #16 was admitted on 7/2/09 with diagnoses including congestive heart failure, generalized muscle weakness and hypoxemia.	G 172		

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G 172	Continued From page 24 Under Coordination/Plan on the second page of a nursing note dated 7/17/09, the nurse documented contact with the occupational therapist secondary to Patient #16's "husband not feeling comfortable assisting c (with) ADLs (activities of daily living)." On 7/21/09, Patient #16 was readmitted to the hospital secondary to an exacerbation of congestive heart failure with hypoxia. The patient was discharged from the hospital on 7/23/09. A registered nurse completed a resumption of care (ROC) on 7/25/09. On 8/4/09 in the afternoon during a home visit, Patient #16 was short of breath and struggled to ambulate around her apartment with oxygen. The clinical record, including case conference notes, lacked documentation indicating a CNA was considered to assist Patient #16 with ADLs. There was no documentation indicating the RN called the physician to report the husband was uncomfortable assisting the patient with ADLs and request an order for a CNA to provide assistance. Patient #18 Patient #18 was admitted on 6/12/09 with diagnoses including pressure ulcer of the buttock, venous ulcers of the lower extremities, venous insufficiency and chronic obstructive pulmonary disease. The care plan (CP) prepared by the registered nurse (RN) and dated 6/12/09 for Patient #18 included orders for the home health aide (HHA) to	G 172		

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G 172	Continued From page 25 assist the patient to use the toilet "at the client's request." The CP lacked care directions for the HHA to follow should the patient be incontinent. On 6/22, 6/26 and 7/24/09, the HHA documented Patient #18 was provided with bowel and bladder incontinent care. The clinical record lacked documentation indicating the RN re-evaluated Patient #18's personal care needs in order to update the HHA care plan.	G 172		
G 173	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and necessary revisions. This STANDARD is not met as evidenced by: Based on record review and observation, the registered nurse failed to make necessary revisions in the plan of care for 1 of 25 patients (Patient #16). Findings include: Patient #16 Patient #16 was admitted on 7/2/09 with diagnoses including congestive heart failure, generalized muscle weakness and hypoxemia. Under Coordination/Plan on the second page of a nursing note dated 7/17/09, the nurse documented contact with the occupational therapist secondary to Patient #16's "husband not feeling comfortable assisting c (with) ADLs (activities of daily living)."	G 173		

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G 173	Continued From page 26 On 7/21/09, Patient #16 was readmitted to the hospital secondary to an exacerbation of congestive heart failure. The patient was discharged from the hospital on 7/23/09 and a registered nurse completed a resumption of care (ROC) on 7/25/09. On 8/4/09 in the afternoon during a home visit, Patient #16 was short of breath and struggled to ambulate around her apartment with oxygen on. A certified nursing assistant (CNA) would have been appropriate to help Patient #16 with ADLs. The clinical record, including case conference notes, lacked documentation indicating the services of a CNA were considered. There was no documentation indicating the RN called the physician to report the husband's situation and request an order for a CNA assist with the ADLs.	G 173		
G 176	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs. This STANDARD is not met as evidenced by: Based on record review and interview, the nurse failed to notify the physician regarding the needs of 1 of 25 patients (Patient #13). Findings include: Patient #13 Patient #13 was admitted on 7/22/09 with	G 176		

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G 176	Continued From page 27 diagnoses including pressure ulcer, non-insulin dependent diabetes mellitus, a right sided below the knee amputation and a left sided above the knee amputation. The registered nurse (RN) saw the patient four times after the start of care. The RN's notes indicated Patient #13 did not have a glucometer and was not checking his blood glucose levels. There was no documentation in the clinical record indicating the physician was notified that the patient was not checking his blood sugars as ordered in the plan of care. On 8/3/09 prior to the home visit, the RN explained the patient did not have a working glucometer and did not want one as he did not want to check his blood sugars.	G 176		
G 177	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse counsels the patient and family in meeting nursing and related needs. This STANDARD is not met as evidenced by: Based on clinical record review, the agency failed to ensure the caregiver was adequately trained and able to perform wound care appropriately for 1 of 25 patients (Patient #13). Findings include: Patient #13 Patient #13 was admitted on 7/22/09 with diagnoses including pressure ulcer, non-insulin dependent diabetes mellitus, a right sided below the knee amputation and a left sided above the	G 177		

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G 177	Continued From page 28 knee amputation. The plan of care (POC) indicated skilled nursing (SN) was to see Patient #13 two times a week for nine weeks. The SN was to teach the caregiver all aspects of the wound care. The caregiver was to change the dressing every day. According to documentation on a nursing note dated 7/28/09, SN performed the wound care and instructed the patient and caregiver regarding the care process as well as the healing process. Documentation on a nursing note dated 7/31/09 revealed SN performed the dressing change and ..."instructed skin care and relief of pressure ulcers ..." The clinical record lacked documented evidence the registered nurse had observed the caregiver perform the wound care (ensuring the caregiver understood all instructions and was able to provide the care properly while using aseptic technique, dispose of the soiled dressing, etc.)	G 177		
G 224	484.36(c)(1) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section. This STANDARD is not met as evidenced by: Based on record review, the agency failed to provide adequate written care instructions for the home health aide to provide care for 1 of 25 patients (Patient #18).	G 224		

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G 224	Continued From page 29 Findings include: Patient #18 Patient #18 was admitted on 6/12/09 with diagnoses including pressure ulcer of the buttock, venous ulcer of the lower extremities, venous insufficiency and chronic obstructive pulmonary disease. The care plan (CP) prepared by the admitting registered nurse (RN) and dated 6/12/09 for Patient #18, included orders for the home health aide (HHA) to assist the patient to use the toilet "at the client's request." The CP lacked orders for the HHA to follow for an incontinent patient. On 6/22, 6/26 and 7/24/09, the HHA documented bowel and bladder incontinent care was provided for Patient #18.	G 224		
G 229	484.36(d)(2) SUPERVISION The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks. This STANDARD is not met as evidenced by: Based on record review and interview, the agency failed to ensure home health aides were supervised by a registered nurse at least every 14 days for 3 of 25 patients (Patients #18, 7, 10). Findings include: Patient #18	G 229		

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G 229	Continued From page 30 Patient #18 was admitted on 6/12/09 with diagnoses including pressure ulcer of the buttock, venous ulcer of the lower extremities, venous insufficiency and chronic obstructive pulmonary disease. Patient #18 was readmitted to an acute care facility on 6/15/09 and returned home on 6/19/09. The resumption of care orders dated 6/20/09 included a home health aide (HHA) for personal care assistance two times a week for seven weeks. Skilled nursing notes in Patient #18's clinical record revealed the registered nurse (RN) performed a HHA supervisory visit on 6/22/09 and on 6/26/09. According to documentation in the clinical record, the HHA saw Patient #18 seven more times over the next five weeks. A RN saw the patient seven more times over the next five weeks. The clinical record lacked evidence of a supervisory visit by the RN after 6/26/09. Patient #7 Patient #7 had a Start of Care (SOC) with the agency of 11/19/08. Her diagnoses included multiple sclerosis, contractures and depression. She was wheelchair bound and paralyzed with the exception of her left hand. She was receiving Home Health Aide (HHA) visits 2 times a week for 9 weeks during the Recertification period of 5/18-7/16/09. The HHA visits were for assistance with personal care.	G 229		

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G 229	Continued From page 31 Review of Patient #7's medical record disclosed that the file lacked documented evidence of supervising visits of the HHA being conducted by the registered nurse within the specified time frames. There were no supervising visits documented from 6/1 to 6/15/09. In an interview with the Director of Nurses (DON) on 8/4/09, the DON concurred that there were no supervisory visits for a time period of fifteen days. Patient #10 Patient #10 had a SOC with the agency of 6/3/09 with diagnoses of dementia, Paget's Disease and a pressure ulcer of the buttocks. She resided with an adult age son. The patient was receiving HHA visits of 2 times a week for 3 weeks during the Certification period of 6/13-8/01/09. The HHA visits were for personal care of the patient. Patient #10 received HHA visits from 6/16-7/3/09. The file lacked documented evidence that any supervisory visits were conducted by registered nurse staff. In an interview with the DON on 8/6/09, it was agreed that no supervising visits had been made.	G 229		
G 337	484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This STANDARD is not met as evidenced by:	G 337		

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Based on record review, home visit review and interview, the agency failed to ensure that a comprehensive assessment of medications was completed and medication profiles were current for 11 of 25 patients (Patients #2, #3, #4, #20, #6, #7, #10, #13, #15, #16, #17).

Findings include:

Patient #2

Patient #2 was admitted to the agency on 7/24/09, following an acute and skilled care facility admission. He resided in an assisted living facility. Review of his medication profile revealed that the registered nurse documented Patient #2 was to receive Spiriva inhalent, one capsule by mouth (PO) daily. Patient #4 also received Advair diskus 250/50, one puff twice a day. Both of these were new drugs. An interview with the primary registered nurse confirmed she was the admitting nurse. This nurse explained that although the Spiriva was inhaled, she indicated by mouth because "the inhaler went into the mouth." The RN confirmed that the Advair diskus was also administered the same way, the inhalant mouthpiece placed in the mouth and the medication was inhaled. The RN acknowledged the Spiriva should have been documented as inhaled daily. The RN acknowledged that documenting the Spiriva to be taken 'one capsule by mouth" could be interpreted as the Spiriva medication was to be swallowed, not inhaled.

Comparison of Patient # 2's medications on the plan of care/medication profiles, to his medications at the assisted living revealed a jar of Miconazole Nitrate 2% topical fungal powder to be applied to the reddened areas. This jar was

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labeled with Patient #2's name. It was located on the top of a bathroom cabinet. The assisted living staff and the RN from the home health agency denied any knowledge of this medication or it's purpose. The home health visit also revealed Patient #2 required oxygen continually, but this was not on his medication profile.

Patient #3

Patient #3 was admitted to the agency on 5/14/09 with the primary diagnosis of a pressure ulcer of the right hip. Patient #3 resided in an assisted living facility. A home visit was made on 8/5/09, accompanying the licensed practical nurse. After the patient visit was completed the LPN spoke with Patient #3's primary caregiver for the shift. She asked if there were any new medications and asked if the Tylenol was still being given as needed. The primary caregiver confirmed there were no new medications, but the Tylenol was being given routinely, every four hours. The LPN did not ask to see the new order. The LPN replied that she did not check the med profiles, because that was the nurse's (RN) responsibility.

A medication profile comparison was done of Patient #3's current medications with the primary caregiver after the LPN left the facility. It was confirmed the Tylenol had not been changed to every four hours routinely and had only been given twice so far this month. Other discrepancies between the facility's medication list, with the agency's physician orders/medication profile were:
1) The facility was giving enteric coated aspirin and crushing it, although the physician's orders did not indicate enteric coated.
2) Bactrim had been reordered on 7/13/09, one

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pill twice a day, for 14 days, to be completed on 7/27/09. This had not been added to the medication profile.
3) Xanax was ordered every eight hours but the med profile indicated it was to be every six hours.
4) Milk of Magnesia was ordered if there was no bowel movement in three days, but this was not on the medication profile.

Patient #4

Patient #4 was admitted to the agency on 6/18/09 following an acute care hospitalization for deep vein thrombosis. Patient #4's post hospital plan of care included titrating Coumadin doses to maintain a therapeutic level. The clinical record revealed the admitting dose of Coumadin was 2.5 milligrams (mg) daily. There was no evidence the medication profile sheet in the clinical record was updated with any changes.

A home visit for Patient #4 was conducted on 8/5/09. Review of the medications that Patient #4 was currently taking revealed her Coumadin dose had been changed several times from the initial dose. On 6/23/09, the Coumadin dose was changed to 2.5 mg on Sunday, Monday, Wednesday, Friday and Saturday. On Tuesday and Thursday, Patient #4 was to receive 5 mg of Coumadin. On 6/29/09, the Coumadin dose was changed again to alternating 2.5 mg with 5 mg every other day. On 7/28/09, the Coumadin was changed again to 3 mg alternating with 5 mg every other day. A conversation was overheard with the physical therapist and the caregiver. The caregiver was asked if there were any new medications, but not if any medications had been changed. The caregiver replied there were no new medications.

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Patient #20

Patient #20 was admitted to the agency on 8/24/08. She was legally blind and required someone to prepare her medications. Until the agency was able to get community assistance, the nurses were pre-filling the medication planners. The medication profiles for 8/24/08, 9/11/08 and 12/20/08, revealed an order for Hydrochlorothiazide (HCTZ) 12.5 mg was ordered during the 9/11/08 period, but discontinued by 12/20/08. Review of the clinical record revealed the LPN put HCTZ in the med planner on 12/30/09. There was an order for the HCTZ to be resumed on 12/30/08, but the medication profile was not updated.

Patient #6

Patient #6 was started on service on 6/26/09 with the diagnoses of open wounds of the legs and arms and dementia. The patient had a past history of Methicillin Resistive Staph Aureus (MRSA). She was wheelchair bound due to a previous stroke and lived in a group home.

Review of the record disclosed a Medication Profile dated 6/26/09. On the profile was Bactrim, an antibiotic, to be given two times a day by mouth with a start date of 1/1/08. While at a home visit with Patient #6, the nurse (Employee #2) was asked if the patient medication profile was current. When the nurse (LPN #1) replied that she believed that it was current, the nurse (Employee #2) was asked if the patient was still receiving the Bactrim. The nurse Employee #2) responded that the patient had not taken Bactrim

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in "a long time." Patient #6's medication current medication bottles were then checked. Bactrim was not one of the current medications. The medication profile was not accurate.

Patient #7

Patient #7 had a Start of Care (SOC) with the agency of 11/19/08. Her diagnoses included multiple sclerosis, contractures and depression. She was wheelchair bound and paralyzed with the exception of her left hand.

Review of Patient #7's record disclosed a note from her physician stating that he was adding a low dose naltrexone (an opoid antagonist) 4.5 mg daily to her medications. Review of the Medication Profile in the patient record revealed the profile had not been updated since 1/15/09 and that the new medication was not on the profile.

Patient #10

Patient #10 had a SOC with the agency of 6/3/09 with diagnoses of dementia, Paget's Disease and a pressure ulcer of the buttocks. She resided with an adult age son.

The patient had a resumption of care on 6/12/09 following a hospital stay. New medication orders, after the hospital stay, included Depakote Sprinkles 125 mg times three by mouth every evening, discontinuation of Norco, Levothyroxine 0.025 mg by mouth daily and a Fentanyl patch, 25 mcg. to be applied topically every 72 hours. Review of the Medication Profile disclosed that the profile had been reviewed on 6/30/09. However, the Narco had not been discontinued

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G 337	Continued From page 37 on the profile, nor had the Depakote Sprinkles, the Levothyroxine or the Fentanyl patch been added to the list of medications. Patient #13 Patient #13 was admitted on 7/22/09 with diagnoses including pressure ulcer, non-insulin dependent diabetes mellitus, a right sided below the knee amputation and a left sided above the knee amputation. On 8/4/09 in the morning during a home visit, Patient #13 revealed he took the following medications: -- Temazepam 15 milligrams two tablets at bedtime "for at least a year" -- Peptic Relief (generic Pepto Bismol) as needed for indigestion -- Spironolactone 25 milligrams two tablets by mouth every night at bedtime According to the plan of care signed by Patient #13's physician, Temazepam and Pepto Bismol were not ordered. The Spironolactone was ordered to be taken "PRN (as needed) for blood pressure." When interviewed regarding his blood pressure and how he knew whether or not he needed to take the Spironolactone, Patient #13 replied, "I take it every night before I go to bed." Patient #15 Patient #15 was admitted on 7/18/09 with diagnoses including generalized muscle	G 337		

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weakness, peripheral vascular disease and status post emergent femoral popliteal bypass surgery.

On 8/4/09 in the morning during a home visit, Patient #15 indicated he used oxygen at two liters per minute via nasal cannula as needed for shortness of breath during the day and continuously at night for asbestosis.

According to the plan of care (POC), Patient #15 had orders to take Atenolol 25 milligrams one whole tablet at bedtime and Viokase-8 one whole tablet twice a day with meals. Oxygen was not listed under medications on the POC. The body of the POC indicated the patient was to have oxygen at two liters per minute via nasal cannula at night.

The medication profile for Patient #15 revealed the patient was to take Atenolol 25 milligrams one half tablet at bedtime and Viokase-8 one half tablet twice a day with meals.

Patient #15 indicated he took Atenolol 25 milligrams one half tablet at bedtime and Viokase-8 one half tablet twice a day with meals. The patient indicated he had been taking one half of a tablet of both the Atenolol and Viokase-8 for "a long time."

Patient #15 indicated he took a multivitamin and a "pain pill" as well. The patient was unable to locate the pain pill bottle. The POC and the medication profile did not list a multivitamin and a pain pill.

Patient #16

Patient #16 was admitted on 7/2/09 with

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diagnoses including congestive heart failure, generalized muscle weakness, hypertension and hypoxemia.

The Medication Profile (MP) for Patient #16 revealed the patient was taking:

-- Calcitriol 0.25 milligrams two tablets by mouth once a day
-- Benicar 20 milligrams by mouth twice a day
-- Oxygen 2.5 liters per minute via nasal cannula continuously

On 8/4/09 in the afternoon during a home visit, Patient #16's spouse (and primary caregiver) indicated the patient's physician had:

-- changed Calcitriol to 0.25 milligrams one tablet twice a day on 7/10/09
-- added Lasix 40 milligrams one tablet every morning on 7/23/09
-- added Spironolactone (Aldactone) 25 milligrams one tablet every morning on 7/23/09
-- changed Benicar to 20 milligrams one tablet once a day on 7/27/09

A nursing note dated 7/9/09 revealed the nurse called the primary care physician to clarify Patient #16 was to be taking Lasix 20 milligrams one tablet by mouth every day.

Patient #16's clinical record contained a nursing note dated 7/16/09. In the lower right hand corner of Page 1 in the Medication section, the nurse documented "assessed med (medication) dispenser to assure Lasix 40 (milligrams) BID (twice a day)."

Patient #16's medication profile (MP) was

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updated on 7/25/09 with an entry of Lasix 40 milligrams one tablet by mouth daily. According to the entry on the MP, this was a change to the Lasix. There was no other entry for Lasix on the MP.

Patient #17

Patient #17 was admitted on 7/3/09 with diagnoses including pressure ulcer to the lower back, atrial fibrillation and abnormality of gait.

Patient #17's plan of care included orders for Coumadin 4 milligrams by mouth daily at 6:00 PM. The first Coumadin entry on the medication profile was dated 7/21/09. The entry was coded as "C" for change and read, "Coumadin 4 mg (milligrams) 2 mg by mouth daily 6PM." The 4 mg had a single line through it and the initials "EG" were in a circle above 4 mg.

A "PT/INR Results - Testing via Finger Stick" form dated 7/6/09 indicated the INR on the same date was 2.6 for Patient #17. The physician's name was on the form and the nurse had signed it. There was no documentation indicating the physician was notified of the result and gave the order to continue with Coumadin 4 milligrams every evening. Under "Comments" an entry read, "Please next draw date July 20th 2009"

A "PT/INR Results - Testing via Finger Stick" form dated 7/27/09 indicated Patient #17's INR on the same date was 2.9. The physician changed the Coumadin dose to 2 milligrams on Monday and 4 milligrams the rest of the week, effective on 7/27/09. The physician signed the form.

Patient #17's medication profile did not include

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G 337	Continued From page 41 the change in the Coumadin dose made by the physician on 7/27/09.	G 337		